HSV infections in immunocompetent hosts at a dosage of 500 mg orally twice per day. Long-term suppression with oral acyclovir is indicated in immunocompromised hosts as well as in patients who suffer recurrent erythema multiforme. Prophylactic doses are usually 400 mg twice a day. Intravenous acyclovir is rarely indicated in immunocompetent patients with HSV infection, although in some immunocompromised hosts with atrophic gastritis, the drug may not be absorbed well orally so that intravenous administration is required. Acyclovir-resistant cases in patients infected with the human immunodeficiency virus require treatment with intravenous foscarnet sodium or vidwarabine. Topical treatment with trifluorothymidine (trifluridine) and 5-(3-hydroxy-2-phosphonyl methoxy) propyl cytosine (HPMPC), an acyclic nucleoside phosphonate, has also been used effectively in some cases. Other helpful measures may include local care with cool compresses or sitz baths, topical anesthetics such as 2% to 5% lidocaine gel or ointment, and pramoxine ointment or lotion. A newly released agent, EMLA cream (a eutectic mixture of local anesthetics), may also be effective in relieving pain when applied topically under occlusion.

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Disorders of the Female Genitalia

IN THE PAST DECADE, important changes have occurred in the diagnosis and management of vulvar skin disorders and chronic pain syndromes. In 1988 the International Society for the Study of Vulvovaginal Diseases replaced the old "vulvar dystrophies" nomenclature with "nonneoplastic epithelial disorders." In the new system, lichen simplex chronicus replaces "hyperplastic dystrophy" for skin thickened by rubbing or scratching. Although it is logical to call vulvar cutaneous diseases by dermatologic names, the fact that three unrelated disorders all start with the word lichen often confuses nondermatologists.

Lichen sclerosus is a progressively scarring process that gradually obliterates the vulvar architecture, narrowing the vaginal introitus. It occurs at any age and can involve other areas of the body, but does not affect vaginal mucosa. New studies have shown that clobetasol propionate 0.05% cream is far more effective in treating lichen sclerosus than 2% testosterone ointment, which is no longer recommended for any vulvar condition. The overuse of clobetasol and other high-potency corticosteroids, however, has been found to cause steroid rebound dermatitis, a rosacea-like erythema, and burning of the vulva similar to perioral dermatitis of the face.

Lichen planus is a cutaneous disease that also affects mucous membranes. A mucosal subtype of lichen planus is one of the causes of erosive or desquamative vaginitis. In other cases, a biopsy for immunofluorescence confirms bullous or cicatricial pemphigoid or pemphigus. Any erosive mucosal disorder may cause vaginal strictures and introital scarring.

Vulvodynia is defined as vulvar burning (stinging, irritation, rawness) rather than itching, which is still known as pruritus vulvae. Constant vulvodynia without visible skin signs may be a cutaneous dysesthesia (pudendal neuralgia or reflex sympathetic dystrophy). Cyclic flares of vulvovaginal irritation with or without vaginal discharge may be due to chronic recurrent candidiasis or hypersensitivity to *Candida* species. Dyspareunia may be the result of vulvar vestibulitis—introital pain at the orifices of Bartholin's and Skene's glands—or secondary vaginismus due to long-standing discomfort. Selecting the appropriate treatment depends on recognizing the primary problem. Dysesthetic vulvodynia (unremitting burning more common in postmenopausal patients) responds to low-dose tricyclic antidepressants (amitriptyline hydrochloride or nortriptyline hydrochloride) or trazodone hydrochloride, probably on the same basis that these medications are effective for postzoster neuralgia. (Younger patients with dysesthetic vulvodynia may also have interstitial cystitis, urethral syndrome, or fibromyalgia.) Cyclic vulvovaginitis gradually resolves with *Candida* species suppression with fluconazole (Diflucan, Pfizer Pharmaceuticals) or terconazole vaginal cream (Terazol Cream, Ortho Pharmaceutical) applied weekly for several months, tapering to biweekly, then monthly. Because vulvar vestibulitis that has persisted for more than a year may require local surgical excision (vestibulectomy), a gynecologic surgeon experienced in the management of vulvodynia should be consulted.

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Cimetidine for the Treatment of Warts

WARTS ARE a common dermatologic problem in children and in adults. Although various topically applied and physical treatment modalities are used to treat warts, at least 50% of them clear spontaneously within two years after their onset. In view of the discomfort and frequent physician visits associated with commonly used therapy for warts, an ideal therapy might be a parenteral medication that boosts the immune system and hastens the clearance of the wart virus.

Cimetidine has been shown to modulate the immune system, probably by blocking type 2 histamine receptors on suppressor T cells, thereby augmenting cell-mediated immunity. The administration of cimetidine increases mitogen-induced lymphocyte proliferation, inhibits suppressor T-cell function, and increases the reactivity of skin